Guardian Life, P.O. Box 14319, Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: **CHILD CARE PROVIDERS UNITED - CALIFORNIA WORKERS HEALTH CARE FUND**	Group Plan Number: **00079268**	Benefits Effective: _____

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Add Participant/Member Dependents/Family Members ☐ Drop/Refuse Coverage ☐ Information Change

In this form, you will be referred to as an participant/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan the CCPU Health Care Fund selected, other plan documents may refer to you as an participant, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

About You: Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	**CCPU Health Care Fund Provided Identification:** _____	**Social Security Number** Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address	City	State	Zip
Gender Identity: ☐ M ☐ F	Date of Birth (mm-dd-yy)		
Phone (indicate primary): Home Work Mobile			
Email Address (indicate primary)	Home	Work	
Are you married or in a domestic partnership? ☐ Yes ☐ No	Date of marriage/domestic partnership		
Do you have children or other dependents? ☐ Yes ☐ No	Placement date of adopted child		

About Your Job: **Job Title: Childcare Provider**

About Your Family: Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse	Gender Identity:	Social Security Number	
Address/City/State/Zip:	☐ M	Date of Birth (mm-dd-yyyy)	
Phone:	☐ F		

Child/Dependent 1: Address/City/State/Zip: Phone:	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone:	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone:	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone:	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):

You must be enrolled to cover your dependents/family members. ***Benefit reductions apply. Please see plan administrator.***

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Participant/Member

Policy Amount *Check one box only*

☐ $10,000	☐ $20,000	☐ $30,000	☐ $40,000	☐ $50,000	☐ $60,000
☐ $70,000	☐ $80,000	☐ $90,000	☐ $100,000	☐ $110,000	☐ $120,000
☐ $130,000	☐ $140,000	☐ $150,000	☐ $160,000	☐ $170,000	☐ $180,000
☐ $190,000	☐ $200,000*	☐ $210,000	☐ $220,000	☐ $230,000	☐ $240,000
☐ $250,000	☐ $260,000	☐ $270,000	☐ $280,000	☐ $290,000	☐ $300,000
☐ $310,000	☐ $320,000	☐ $330,000	☐ $340,000	☐ $350,000	☐ $360,000
☐ $370,000	☐ $380,000	☐ $390,000	☐ $400,000	☐ $410,000	☐ $420,000
☐ $430,000	☐ $440,000	☐ $450,000	☐ $460,000	☐ $470,000	☐ $480,000
☐ $490,000	☐ $500,000				

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

Add **Voluntary Life for Spouse or Partner Policy**

Amount

☐ $5,000	☐ $10,000	☐ $15,000	☐ $20,000	☐ $25,000	☐ $30,000
☐ $35,000	☐ $40,000	☐ $45,000	☐ $50,000*	☐ $55,000	☐ $60,000
☐ $65,000	☐ $70,000	☐ $75,000	☐ $80,000	☐ $85,000	☐ $90,000
☐ $95,000	☐ $100,000	☐ $105,000	☐ $110,000	☐ $115,000	☐ $120,000
☐ $125,000	☐ $130,000	☐ $135,000	☐ $140,000	☐ $145,000	☐ $150,000
☐ $155,000	☐ $160,000	☐ $165,000	☐ $170,000	☐ $175,000	☐ $180,000
☐ $185,000	☐ $190,000	☐ $195,000	☐ $200,000	☐ $205,000	☐ $210,000
☐ $215,000	☐ $220,000	☐ $225,000	☐ $230,000	☐ $235,000	☐ $240,000
☐ $245,000	☐ $250,000				

*Guarantee Issue Amount

* ***The amount may not be more than 50% of the*** participant ***amount for Voluntary Life.***

☐ I do not want this coverage

LIFE INSURANCE *continued*

Add Voluntary Life for Dependent/Child(ren) Policy

Amount

☐ $5,000 ☐ $10,000*

**Guarantee Issue Amount*

** The amount may not be more than 100% of the participant amount for Voluntary Life.*

☐ I do not want this coverage

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Participant/Member

Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_____ Social Security Number:_____ % _____

Date of Birth (mm-dd-yy): _____ Address/City/State/Zip: _____

Phone: Relationship to Participant/Member:_____

Name:_____ Social Security Number:_____ % _____

Date of Birth (mm-dd-yy): _____ Address/City/State/Zip: _____

Phone Relationship to Participant/Member:_____

Contingent Beneficiary: _____ Social Security Number: _____

Date of Birth (mm-dd-yy): _____ Address/City/State/Zip: _____

Phone Relationship to Participant/Member:_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. The CCPU Health Care Fund maintains beneficiary information.)

Spouse or Partner and dependent/child(ren) – If the intended beneficiary is to be someone other than the participant/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only ☐ Yes ☐ No If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity):

____ Date of Birth (mm-dd-yyyy) (if an individual _____ Address/City/State/Zip: _____

Phone:

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

DETACH ENTIRE FORM AND RETURN TO CCPU HEATH CARE REIMBURSEMENT FUND

Mail: CCPU - Voluntary Life PO Box 57027 Irvine, CA 92619 Email: benefits@ccpuhealth.org

Guardian Group Plan Number: 00079268 Please print participant name:

- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I attest that the information provided above is true and correct to the best of my knowledge.
- "California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law requires that insurers offering Accident, Cancer, Critical Illness and Hospital Indemnity policies or certificates must require that the person to be insured is covered for essential health benefits or minimum essential coverage as defined in federal law. If you do not have such essential health benefits or minimum essential coverage as defined in federal law, you may not enroll for Accident, Cancer, Critical Illness or Hospital Indemnity Coverage. By your signature below, you affirmatively attest that you, and any dependents to be covered, are covered by essential health benefits or minimum essential coverage as defined in federal law.

SIGNATURE OF **PARTICIPANT**/MEMBER X _____ DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing or any materially false information, conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

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New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

DETACH ENTIRE FORM AND RETURN TO CCPU HEALTHCARE REIMBURSEMENT FUND

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